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ABSTRACT

This paper reports on a one-year study supported by the European Regional Office of the World Health Organization. The aims of the study were to develop a methodological approach to identify national practices in health manpower and, in particular, health manpower planning, and to explore them in relation to the European "health for all" strategy. The British National Health Service was used as a case study. The project's objectives and methodology are outlined, and the main findings of the study are reviewed. The paper concludes by suggesting the applicabilty of the methodology to studies in this area and possible modifications to explore primary health care more directly. A copy of the questionnaire used in the study is appended as well as a report on a workshop on Health Manpower Development held at the University of Leeds (England) in February, 1985. (Author/JD)

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Investigating practices
health manpower planning

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World Health Organization
Regional Office for Europe
Copenhagen

Investigating practices
n health manpower planning

Report on a country case study

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ABSTRACT

This paper reports on a one-year study supported by the European Regional Office of the World Health Organization. The aims of the study were to develop a methodological approach to identify national practices in health manpower and, in particular, health manpower planning, and to explore them in relation to the European health for all strategy. The British National Health Service was used as a case study. The project's objectives and methodology are outlined, and the main findings of the study are reviewed. The paper concludes by suggesting the applicability of the methodology to studies in this area and possible modifications to explore primary health care more directly.

This study was undertaken under a contractual service agreement with the Nuffield Centre for Health Services Studies, University of Leeds.

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1. INTRODUCTION

Given the economic climate of the 1970s and 1980s with its growing concern for the containment of costs of health and other care, interest in health manpower development (HMD) has increased. Issues are more and more often being raised regarding numbers of staff and their justification, how staff are deployed and the quality of their work, as too are questions over the content and relevance of education and training for health workers. In the context of medical manpower, anxiety has focused upon three potential problems: the mismatch between supply and demand, together with the development of additional specialties and subspecialties; maldistribution (geographically and by specialty); and improper utilization, especially the lack of progress towards a team approach in the provision of health care. Indeed, the study of such issues was advocated in 1981 in the third meeting of the Advisory Committee on HMD and again in 1984 in the conclusions of a seminar on medical specialization in relation to health needs, both held by the WHO European Regional Office.

Concurrently, with the adoption by the World Health Assembly in 1977 of health for all (HFA) as the main social target of governments and WHO, the Alma Ata Declaration of 1978, and the resultant HFA strategy and target documents endorsed by the Member States of the European Region in 1980 and 1984[a], attention focused on the implications of achieving HFA through the (re)orientation of health

[a] See in particular, Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1985.

policy towards the concept of primary health care (PHC). This strategy presented particular challenges to many Member States in the European Region where health sector institutions were already well established, and where patterns and types of provision of medical and other services - and the public's expectations of them - were set.

Given the level of interest in health manpower issues and the changes introduced in countries of the European Region before the endorsement of the regional strategy, there was at least a prima facie case for reviewing current manpower practices and their consistency with HFA policy objectives. It was at least plausible that those practices, shaped by professional and technological determinants, would create a momentum and a sense of direction significantly different from HFA. One major consideration was the degree of integration, or at least collaboration, between sectors (for example, health and higher education) and/or agencies (for example, training institutes and health service authorities) with respect to the identification of tasks and roles, numbers required, education, training and development, and deployment in service institutions (hospitals, health centres, practice offices, and so on).

Following an approach to the Nuffield Centre (Department of Social Policy and Health Services Studies, University of Leeds) - a WHO collaborating centre - to assist the Regional Office in the exploration and development of health manpower issues, a consultation was held in the Regional Office in April 1982 to discuss the value and possible format of a study to review the actual situation in Member States and to test suitable methodologies. Subsequent contacts between the Nuffield Centre and the Regional Office helped

clarify the focus and orientation of the study. As a result, an agreement was reached in October 1983 for the Nuffield Centre to embark on a review of health manpower practices within the United Kingdom as a one-year pilot study (April 1984-1985).

The pilot study investigation, centred on the United Kingdom and specifically the British National Health Service, was to attain three objectives:

- to identify and describe practices in health manpower and, in particular, health manpower planning (HMP);

- to examine such practices against the aims of the WHO strategy for HFA with a view to their compatibility and supportiveness;

- to investigate current health manpower practices perceived as supportive of HFA.

2. THE ORGANIZATIONAL AND PLANNING CONTEXT

Although the National Health Service (NHS) is funded by the central government, the actual delivery of health services in individual localities is delegated to health authorities. They are statutory corporate bodies with a degree of independence from the central government although they are not part of elected local governments either. The result of this arrangement is that the NHS cannot be treated as monolithic; for instance, plans, priorities and personnel policies vary among health authorities. This is not to say that central control is wholly absent, for the planning system described below is intended to ensure that central government priorities are reflected in local decisions. Furthermore, there is a national system of pay bargaining by which pay scales, and in some cases job descriptions, are imposed upon the local health services.

Arrangements for the education and training of health professionals are varied and complex. They occur partly within the health sector and partly within the education sector, and involve a multiplicity of agencies operating largely outside the control of NHS management. Moreover, the influence of central government is somewhat attenuated in this area since, although systems of state licensing for health professionals exist, these systems are largely delegated to the professions themselves.

In terms of actual numbers of staff employed, the NHS in the United Kingdom has a workforce of about 1.1 million (1983 figures). Of these, 9.5% are medical and dental staff, either working predominantly in hospital services (46%) or in the community services and general practice (54%).

Eight and one half percent of all employees are working in the primary health care context, that is, as general medical practitioners, general dental practitioners and other practitioners, community midwives, district nurses or health visitors. Such figures exclude any paramedical or ancillary staff (receptionists, practice nurses and so on) that the general practitioners may be employing. It is estimated that one in four practices employs a practice nurse. The actual numbers or percentages are only slightly different for England and Wales, the focal points of this study.

In addition, it must be noted that a small private health service is operating, and that this is a significant factor in relation to health manpower. Firstly, it provides an alternative and an additional source of employment to workers in the NHS, with the financial attraction of private practice. Secondly, the staff of such private health facilities receive, at least at present, their education and training within the NHS or related institutions. A double drain on the resources of the NHS can thus be inferred.

The planning system, although it only relatively recently became formalized in the NHS, can be seen as an attempt to draw together these various agencies and systems. Previously, planning was incremental, focused on buildings and tended to be outside of nationally accepted policies. These circumstances soon came to be regarded as intolerable, especially by central policy-makers. Three reasons were to the fore: firstly, a growing awareness of the need for corporate management; secondly, a general desire, centrally, for greater cost control; and, thirdly, changes occurring in health care provision, particularly those associated with the development and expansion of high

technology medicine which also highlighted the need for greater cost consciousness. In consequence, a comprehensive formal planning system was introduced in 1976.

Since its initial formalization in the NHS, this system has been the subject of considerable debate and investigation, and thus has undergone several metamorphoses. The most important change introduced was an emphasis on strategic planning within the context of national policies and priorities, coinciding with a shift in 1982 to the current organizational structure encompassing the Department of Health and Social Security (DHSS), and regional and district health authorities.

Health plans are now produced on two levels. The first is the district health authority (DHA), each of which is required to prepare a strategic plan covering a ten-year planning period. In addition, each DHA must produce a short-term (two-year) programme that outlines the steps that will be taken towards the implementation of national and local policies outlined in the strategic plan. The second level of activity occurs at the regional health authority (RHA). Each RHA (there are 14 in England but none in Scotland and Wales, the latter two being viewed as regions in their own right) is responsible for preparing a region-wide strategic plan that draws together the strategic plans from the district health authorities within its boundaries. Prior to this task, however, each RHA must prepare and circulate to its district health authorities an outline strategy that identifies the issues seen within the RHA as being of particular concern. These outline strategies must be approved nationally, after which they become the foundation upon which each DHA prepares its

strategic plan. Table 1 gives an indication of the relevant stages and the timescale necessary for the strategic planning process.

Table 1. NHS planning system - strategic planning (1985-1994)

LEVEL	TASKS	TIMESCALE
RHA	Prepare outline strategy and send copy to DHSS	Mid-May 1984
	Amend subject to DHSS comments and send outline strategy to district health authorities	End of May 1984
	Prepare regional strategic plan incorporating DHA strategic plans and send to DHSS	End of March 1985
	Send summary report to DHSS on main changes outlined in short-term programme and on manpower targets	End of May 1984, and annually by end of March
DHA	Prepare ten-year strategic plan based upon regional outline strategy	Date to be agreed between DHA and RHA
	Prepare and submit to RHA and district short-term programme including manpower targets	Date to be agreed between DHA and RHA

Source: Resource distribution for 1984/85, service priorities, manpower and planning. Department of Health and Social Security, January 1984 (Circular HC(84)2/LAC(84)4).

As a final element in the planning process, each regional strategic plan is submitted to the DHSS. In this way, the DHSS is able to fit together a composite picture of the degree of adherence to national policies and to identify any deviation from established targets. This so-called "top-down/bottom-up" approach to planning is

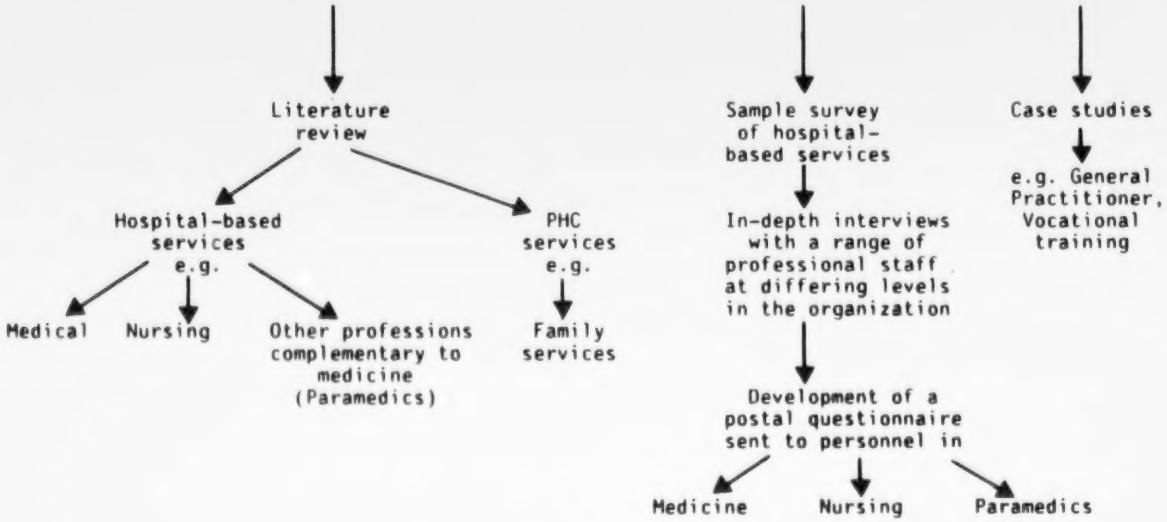
justified on the grounds that it provides an opportunity for the Government's policies and priorities to be reconciled with available resources whilst it also enables health authorities to appraise systematically their own services and to influence the Government. Thus, through resource distribution and indications of national priorities, the DHSS seeks to impose its view on the regions, which then restate specified issues to fit their own contexts and set the boundaries for district plans. The district health authorities explore their own priorities and needs through planning teams and/or unit management groups, which are then channelled up the system. And so the cycle continues.

3. METHODOLOGY

To achieve the first objective - "to identify and describe practices in health manpower and, in particular, HMP" - and thus to draw up an inventory of approaches and methodologies employed, it was essential to review both hospital-based services (employing about 91% of all National Health Service staff) and primary health care services. A three-pronged strategy as depicted in Fig. 1 was applied in order to glean details on the breadth of approaches.

Firstly, a review of recent literature was undertaken on three major health-providing groups - physicians, nurses and paramedical workers. The aim of this review was to identify references in the literature to manpower planning and related issues, the role of the profession(s), methodologies for estimating demand for manpower and considerations of supply. The intention was to identify the issues being discussed within the professions to support the survey findings on actual manpower practice. In addition, in order to cast light on primary health care services, past trends and current initiatives in relation to general practice were explored. Issues examined include current and proposed service planning arrangements, the financing of the service, the Family Practitioner Committee and its new planning role, and manpower issues (the role of the general practitioner and the primary health care team). The literature review thus provided insights into the general context of HMP - including key issues and attitudes - prior to an examination of actual health authority manpower planning practices.

Fig. 1. An overview of methodology (Objective I)


Objective I: To identify and describe practices in health manpower, and, in particular, HMP.
Literature review
Hospital-based services e.g.
Medical
Nursing
Other professions complementary to medicine (Paramedics)
PHC services e.g.
Family services
Sample survey of hospital-based services
In-depth interviews with a range of professional staff at differing levels in the organization
Development of a postal questionnaire sent to personnel in
Medicine
Nursing
Paramedics
Case studies
e.g. General Practitioner, Vocational training

Secondly, and comprising a major part of the study, a sample survey investigation was carried out of current practices in health manpower within hospital-based services. A series of semi-structured interviews served as a starting point for the survey. They were conducted with key actors in the management and planning field (medical, nursing, paramedical and personnel staff) at a range of levels in the NHS (region, district and unit) in a small number of health authorities. The objectives of this exercise were to clarify areas of concern to actors in the manpower field and to ensure that the questions raised by the interviewers were intelligible and relevant. Accordingly, the interviews were quite lengthy, lasting one to two hours. Choice of individuals and health authorities was guided by advice received from regional manpower planning specialists as to "places of particular interest" or "places with developing expertise in the field". Given below is an overview of areas explored. Each was addressed in an open-ended manner, allowing the pursuit of relevant lines of enquiry as these emerged in the interview.

A. Contextual issues

- What are the financial and other constraints on manpower planning at this level in the organization?

- What is the general approach to planning ("top-down" vs. "bottom-up" approach)?

B. Respondent's role in manpower planning

- What are your tasks and responsibilities in manpower planning?

- What are the responsibilities of others in manpower planning?

C. Formulating manpower requirements

- How are the numbers of staff required identified (norms vs. demand vs. needs-based approaches)? (If norms, which ones and from what source?)

- Is manpower planned by staff group (nurse, physician, etc.) or client care groups (elderly, mentally ill, etc.)?

- What consideration is given to skill mix, roles, etc.?

- If a new/another physician is to be appointed, are non-physician manpower implications thought through?

D. Manpower supply

- What information exists on potential sources of supply (e.g. manpower stock, labour market survey, register of available unemployed nurses)?

- What influences are there over local training facilities and sources of recruitment (internal and external), and how extensive are they?

- If a key person cannot be recruited, what then? Are substitution and role enlargement possible and acceptable?

- To what extent can the health authority influence supply?

- Do any specific policies exist for encouraging women to return to work (crêches, flexibility of hours)?

E. Implementation

- Who is responsible for the implementation of the manpower content of the plan? What measures exist to ensure implementation?

Building on this pilot interview survey, a postal questionnaire (Annex 1) was drawn up and circulated to one in three district health authorities in England and Wales. Scotland and Northern Ireland were excluded from the study owing to pressures of time and limitations of resources. A district focus was adopted because of their key role in the planning process in both operational and strategic terms, when considering long-term demand and supply and their achievement. For their part, the regions perform a coordinating and monitoring role in the manpower process. The actual questions asked were based on experience gained during the interview survey.

Questionnaires were sent to four groups of persons in the district health authorities at district and unit level:

(a) district personnel officers, whose roles in the manpower field can be described as coordination and, given the current tight financial climate, manpower control;

(b) nurses, specifically the chief nursing officers and directors of nursing services for the elderly and for the community (the latter two were chosen because

they differed from chief nursing officers in terms of their role and of the specific interest of their respective client groups); and

(c) district head physiotherapists and district occupational therapists, representing two major paramedical groups.

Sampling was constructed to obtain representativeness in terms of:

- teaching vs. non-teaching districts;
- those with and without an occupational therapy or physiotherapy training school;
- urban vs. rural health authorities; and
- locations with higher or lower proportions of adults over 65 years.

An overall response rate of 53% was achieved. Actual response rates varied by professional group: that is, personnel (34%), nursing (50%), occupational therapists (71%), physiotherapists (64%).

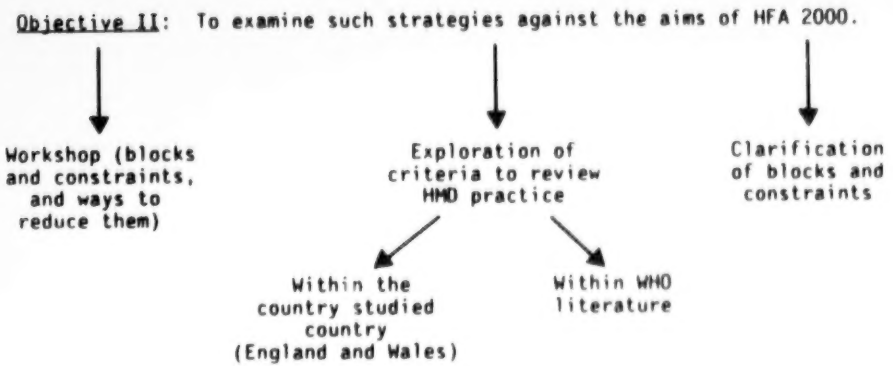
A short letter was also addressed to the district medical officer in each of the sampled health authorities. This letter asked two questions: firstly, how a decision was reached on the need for a new consultant post and, in particular, what criteria were employed; and, secondly, how a decision was reached to create a new junior medical staff post and what the policies were on the required ratios between junior and consultant staff. A response rate of 78% was achieved, increasing the overall survey response rate to 57%.

Taken together, the multiple methods employed to explore the first study objective cast differing but complementary light on current manpower practices in the British NHS. The literature review highlighted areas of concern within the professions, as expressed in their journals or in other reports on manpower issues, as well as methodologies for estimating manpower demand in particular. The survey data, while focusing only on hospital-based manpower, nevertheless exemplified the breadth of practice for planning health manpower. The later exploration of case studies in PHC in connection with the third study objective provided a necessary extension to embrace HMP across the NHS.

The investigation of the second and third objectives was by no means straightforward. To assist in their exploration, a workshop on HFA and HMD was held, with participants from the NHS and other European countries (see Annex 2 for objectives and participants). Discussions centred upon checking the findings arising from the exploration of the first study objective, and then upon obstacles, difficulties and constraints in the process of planning health personnel and potential ways to overcome them within the context of reorienting health services towards PHC.

To further explore the second objective of the study (see Fig. 2) - "to examine such practices against the aims of HFA with a view to their compatibility and supportiveness" - sets of criteria were constructed to review current manpower practices and to identify those of potential. An ideal for health manpower planning was postulated on the basis of previous practical experience in the area and from reviewing relevant literature on manpower planning. This ideal took into account an analysis

Fig. 2. An overview of methodology (Objective II)


Objective II: To examine such strategies against the aims of HFA 2000.
Workshop (blocks and constraints, and ways to reduce them)
Exploration of criteria to review HMD practice
Clarification of blocks and constraints
Within the country studied country (England and Wales)
Within WHO literature

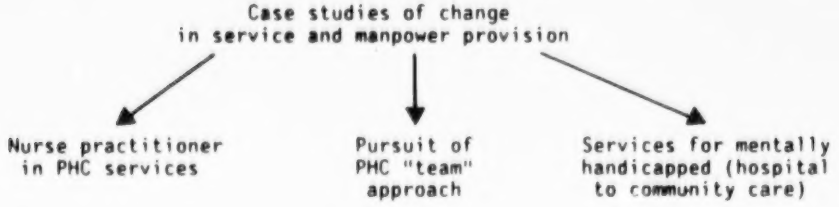
of the relevant WHO European target on planning, education and use of health personnel.[a] Accordingly, strengths and weaknesses in current practices were examined. Then, obstacles and challenges to changes in role, numbers and the like presented within the NHS and its associated professions were elicited to clearly identify their nature and form, thus clarifying potential ways of surmounting them.

Finally, to examine the third objective (see Fig. 3) - "to investigate current health manpower practices perceived as supportive of HFA" - a series of case studies of manpower planning was carried out. These covered the following areas: deployment of a nurse practitioner in the family practitioner services; the pursuit of a primary health care team approach in a health centre in a northern industrial city; and planning for a shift in services for the mentally handicapped from hospital provision to care in the community. These were chosen as examples of innovative practice, involving a reassessment of the role of traditional health manpower. Interviews were carried out with key actors in these settings, exploring the philosophy behind the approach, its rationale and health manpower implications.

[a] Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1985, pp. 141-144.

Fig. 3. An overview of methodology (Objective III)

Objective III: To investigate current health manpower practices perceived as supportive of HFA.



4. AN OVERVIEW OF THE FINDINGS

Objective I: To identify current practices in health manpower

In relation to the first objective of the study, the literature review and the survey material provided several insights. From the literature review, five general points emerged.

(a) Attempts to maintain "professional" status:

For both nurses and paramedics, considerable concern was expressed about their exact duties and how to create a clearly defined role separate from that of the medical profession and other competing groups. Within nursing, for example, debates about the "specialist nurse" in both clinical (the clinical nurse, the midwife) and community (practice nurse, nurse practitioner) contexts highlight intraprofessional divisions. Another example is the discussion about whether the "nursing assistant/auxiliary", being an untrained person, is an aide or assistant rather than a nurse. Similarly, among the paramedics, there is significant variation in their control over the discharge of their duties without immediate medical supervision; for instance, physiotherapists and occupational therapists experience relatively more autonomy than radiographers. The very expressions of concern over role and professional status are perhaps indicative of a lack of recognition and success in contrast to physicians whose role and dominance is well established.

(b) Increasing specialization:

Physicians, in particular, by building on their established professional role, have multiplied specialized areas involving increasingly more specific skills and expertise, and, at the same time, further increasing their professional status. Nurses appear to be trying to emulate this development, perhaps to support their claim to professional status and to establish a separate sphere of operation allied to, but also independent of, physicians.

(c) The lack of a multiprofessional team approach:

Little consideration to the contribution of other groups of personnel to patient care is given in the medical literature. Within nursing, that which exists centres only on the nurse-physician relationship, arguing for nursing's independent and equal status. Scant attention, however, is given to the relationship between nurse and paramedical worker, or other staff links.

(d) The mismatch of supply and demand:

Fears are being expressed about medical unemployment and, more specifically, of an overproduction of physicians, with the result that an argument is now being put forward for reducing the intake to medical schools. This is usually voiced in general terms, often apart from any detailed analysis of actual numbers and the type (hospital and general practitioners, or specialists within specific branches of medicine) that might be needed to improve the state of health in the population. In contrast, the need to expand training is advocated by the paramedics (for example, occupational

therapists and physiotherapists). Radiographers provide an exception in that there is little pressure for an expanded training programme.

(e) The adoption of a more systematic approach to estimating manpower requirements:

It is among nurses that this question is most hotly debated. Discussion includes the many extant methods, the emergence of new ones and refinement of older ones. The main thrusts of the debate include establishing systematic procedures for estimating staffing requirements, for refining and providing a more substantive basis to professional judgement and finally, as a consequence, reviewing the current deployment of staff. The intention is to provide a less subjective and more systematic assessment of nursing workload, to justify staffing figures and, thus, to resist the increasing attempts to limit and/or reduce nursing manpower within the curtailed financial context and highly controlled manpower context of the NHS.

Such issues are reinforced by the findings of the interview and postal questionnaire survey in the hospital-based sample. There was general agreement concerning the following areas:

- a shift from the use of professional judgement to workload-based methods for estimating staffing requirements is apparent across all groups, physicians to paramedics;

- there are difficulties in achieving supply needs; consequently many strategies are pursued, from increasing part-time openings and changing the staffing mix to offering higher salaries;

- planning manpower is undertaken on a staff-group-by-staff-group basis, and not in relation to a multiprofessional team approach; and, finally,

- the respondents perceive their own role in manpower planning as embracing both the estimation of manpower required and recruiting and training personnel, a positive step towards integrating manpower consideration into the wider planning context.

Objective II: To examine strategies against the aims of HFA

In relation to the second objective, the first task was to construct a set of criteria to evaluate current practices. These criteria were to be consistent with the health manpower component of the European strategy for HFA. To this end, in Table 2 an "ideal" for health manpower practice is outlined involving: the systematic assessment of demand and supply; the adoption of a team approach to identifying manpower requirements, in contrast to a solely occupationally based one; the costs for manpower remaining within available limits; and a general awareness of the manpower dimension in planning. Current practices within the British NHS are depicted in the body of the table for the three occupational categories studied, outlining a range of positions rather than a definitive statement.

What, then, are the obstacles and constraints identified in such current practices? Three main types of difficulties can be elicited.

Table 2. Health manpower practice vs. an "ideal"

"IDEAL" PRACTICE	CURRENT PRACTICE		
	Physicians	Nurses	Paramedics
Awareness of the manpower dimension of planning	Yes; national concern, and increasing local awareness	Yes; major local concern over justifying numbers and roles	Yes; major local concern, attempts to achieve recognition of role and increase numbers
Systematic assessment of manpower requirements, based on:			
Workload together with professional judgement	Use of professional judgement; some examples of workload based	Norms, and professional judgement, leading on to workload-based "dependency" studies	Norms and professional judgement and development of workload based methods
Role and skill mix	Unambiguous and acknowledged role definition; solid professional status	Role questioning (inter and intra nursing); attempts at role enlargement; assertion of professionalism	Seeking to establish accepted role, and professional status
Multiprofessional team approach	Only a few examples in specific areas, e.g. mental illness, mental handicap and geriatrics		
Quality review (effectiveness and efficiency)	Little attention	Increasing attention (quality of nursing care studies)	Staff shortage dominant, discouraging attention here
Systematic assessment of manpower supply, based on:			
Exploration of existing and potential pools of labour	National issue	Local issue	Regional/national issue
Responsiveness of training to service needs	Oversupply	Under direct local control	Undersupply
Costs of manpower taken into account in health services development	Manpower targets exercise, including vacancy review and cash limits		

(a) Those operating in the environment external to the health service:

The example of supply and training of potential health service employees provides an illustration. A local health authority has little or no influence over the production of physicians (numbers and/or skills), greater influence over nurses, and most over ancillary staff. But even where it has influence, it is not the only, nor necessarily the most important source of influence: there are professional associations and trade unions, educational organizations and numerous statutory bodies. Indeed, those occupations, for example physicians, over which the local authority has least control are likely to be key figures in the local health care process. The point to note is that health authorities must operate in such a setting, and thus are not able to have complete control over their destiny. Indeed, they are forced into a reactive stance, accepting the skills and roles of available manpower.

(b) Those operating inside the organization of the health service:

The health service is composed of a variety of specialized professional groups whose interests and objectives focus upon professional developments and loyalties as much as organizational ones. Such interests may be a more powerful determinant of behaviour than formal organizational objectives, plans or policies. The issue of the relative power of each professional group is one that must be addressed.

(c) Those relating to uncertainties in forecasting:

Individuals operating within the health service experience considerable difficulties in forecasting the future, assessing cause and effect links, and so on. Uncertainties over the following pose difficulties: governmental policy (overfinancing, priorities and manpower targets); time lags in manpower planning and production; and resistance to manpower management techniques (productivity, role enlargement). Again, health authorities are forced to react to problems rather than be proactive in pursuit of organizational objectives.

Such constraints are, though, not fixed and immutable; to recognize their existence may be the first step to reducing their all-pervasive control. Each of the following measures has a potential impact on reducing the constraints and enhancing the pursuit of the plans and policies of the organization itself:

- recognizing the current limits of a health authority's sphere of influence (and trying to maximize in areas where it can have influence and therefore extend its boundaries);

- encouraging occupational flexibility within the organization;

- challenging roles and questioning the relevance of current skills; and

- encouraging the retraining of health workers (continuing education).

The characterization of health manpower practices, and the identification of obstacles and constraints in current practice, can be taken a stage further by attempting to explore the characteristics of particular manpower issues and potential constraints. For example, factors involved in unbalanced production and maldistribution of personnel, lack of attention to roles and skills, and the issue of professionalism can be examined as to their definitions and effects on the provision of health services at varying levels in the organization. Ways to modify their impact on current and potential practices can then be suggested. In other words, such factors should not be seen initially to be positive or negative, but rather examined critically with respect to the above areas. It is suggested that through the clarification of such issues more specific checklists to evaluate health manpower practice can be developed. In addition, they could be used to elucidate the ways potential manpower initiatives and innovations may be limited.

Objective III: To investigate current health manpower practices perceived as supportive of HFA

Turning finally to the third study objective, three case studies involving manpower practices that seemed consonant with the aims of HFA were explored. The intention was to clarify the nature of some innovations in the area of PHC and to identify the underlying philosophy that was central to the approach to providing health care. The studies represented quite different and distinct structural developments, ranging from an individual worker's role in a general practitioner surgery (the nurse practitioner) to an account of a health centre

pursuing actively a PHC approach, and to a restructuring of a hospital-based service for the mentally handicapped into a community-based service.

In the nurse practitioner study, it was apparent that here was a manpower practice that filled a gap in current health care provision in the area of health promotion and screening. But, at the same time, the very development of this role raised the issue of professional status - the germs of expansion from the current role to an enlarged one.

In the health centre study, an interesting glimpse was provided into what appeared to be the successful operation of a team approach to the provision of PHC. Finally, the case study of mental handicap services showed the sort of manpower decisions, constraining factors and issues surrounding a shift from a specialized hospital service to a service within the community. Many of the manpower tensions remain to be resolved.

All three of the case studies were linked by their underlying philosophy and motivation for providing service. In each situation, a holistic approach to health care was adopted whereby the patients were situated in their own social, psychological and economic circumstances, and a whole-person assessment rather than a disease model applied. Further, the method adopted was legitimized in terms of the health needs of the patient group rather than the organization's or professionals' requirements. In summary, there was a conscious attempt to increase client involvement in the decision-making process, and to challenge the sole wisdom of professionals. Furthermore, they

indicated a response of primary health care services, to promote health rather than adopt a solely curative or containment policy approach.

5. CONCLUSIONS

The one-year study of health manpower practices in the British NHS has served to accomplish four things:

(a) test out a methodology to explore the subject;

(b) identify current practices and constraints, and suggest ways to overcome such constraints;

(c) begin the exploration of criteria to review manpower practices; and

(d) explore practices potentially supportive to the strategy of HFA.

This report provides a detailed account of the methodology employed and an overview of the findings. For a more extensive discussion of the study and the issues, the reader is referred to Long, et al, Health manpower planning (London, Croom Helm, in press).

Two points, however, must be noted. Firstly, there is a need to replicate the study in terms of findings and methodology in other countries with differing educational and health service arrangements. Secondly, much of the research focus lay on hospital-based services, for they are the main employer of health manpower in the NHS. Suggested areas where research focus could be expanded include: greater attention to PHC, on current and potential developments in the field (for example, the role of the practice nurse vs. other community

nurses); further case studies on shifts from current hospital-based services to services based in the community (for example, mental illness and the elderly); case studies on the operation of a team approach to manpower planning, especially one involving intersectoral arrangements; and exploration of the public-private dimension in health care delivery.

HFA, if it is to become a reality in such a developed health care context as the British NHS with its highly specialized and highly technological base to health services, implies a considerable shift or reorientation of the current concept of health care. However, changing concepts will not be sufficient to achieve HFA targets unless there are corresponding changes in manpower education, training, planning and management.

Annex 1

QUESTIONNAIRE

I would be grateful if you would spare some time to answer the following questions which explore the way manpower requirements are formulated, the match between supply and demand, and strategies which you may have tried and adopted to influence the supply of labour.

The questions are designed to be answered by ticking the appropriate category. In addition, I would like you to amplify your responses where appropriate in as much detail as possible.

Thank you for your help.

A. STAFFING REQUIREMENTS

1. There are many different methods for estimating the requirements for staff. Which of the following do you use? If you are using a combination of methods please indicate one.

   (For paramedics and personnel officers)

   Professional judgement ....
   Norms (please indicate which norms you use) ....
   Workload based method - please elaborate ....
   Other - please specify ....

(For nurses)

Professional judgement	....
Norms (please indicate which norms you use)	....
Telford formula	....
Cheltenham method	....
Goddard method	....
Leicester method	....
Oxfordshire method	....
Rhys Hearn Care Package	....
Aberdeen formula	....
Auld method	....
Other - please specify	....

2. Please can you tell me why you have adopted this particular method(s).

3. What advantages and disadvantages have you found with this approach? Please give as much detail as you can.

Advantages	Disadvantages

4. Do you intend to change your method of estimating staffing requirements in the near future?

YES NO

If so, which method will you be changing to, and why?

5. In your experience, is the estimation of the demand for staff undertaken on a staff group

by staff group basis (i.e., for nurses, doctors, and physiotherapists, etc., independently of each other)?

Totally	....
To a large extent	....
To some extent	....
Not at all	....
Don't know	....

Why do you say this?

6. An alternative approach to this is that of planning staffing requirements across groups, and looking at the joint contribution staff groups (as a multiprofessional team) make to patient care. To what extent has such an approach been operating in your area of activity?

1. Useful approach, and has been adopted	....
2. Useful approach, and starting to do things in this way	....
3. Useful approach, and would hope to pursue it in the near future	....
4. Unacceptable option, tried in the past but did not work	....
5. Unacceptable option - please explain	....
6. Don't know	....

What is the reason for your view?

B. LABOUR SUPPLY

7. Have you ever experienced any problems in recruiting staff?

Never	....
Occasionally	....
Frequently	....
Most of the time	....
Don't know	....

If so, which particular grades of staff did you find it difficult to recruit, and why do you think that was?

8. Which of the following strategies have you employed in attempting to overcome labour supply difficulties? Please tick those which you have tried.

	YES	NO
Advertising campaign (to "sell" the district, showing its attractiveness)	...	...
Mounting a back to "nursing" campaign	...	...
Register of ex-employees (e.g., nurse bank)	...	...
Undertake a labour market survey, to explore the possible sources of recruits	...	...
Attracting more people to take up training places	...	...
Opening and/or expanding training school	...	...
Upgrading posts	...	...
Offering a higher salary/incremental starting point	...	...

	YES	NO
Increasing openings for part-time employment	...	...
Providing crêche facilities	...	...
Enlarging the role of a member of staff to embrace the shortage skill	...	...
Changing the staffing mix	...	...
Retraining existing staff to take on additional skills in the shortage area	...	...
Other - please specify	...	...
None of these, as the supply of labour was never a problem	...	...

Does this combination of strategies work successfully to solve the supply problem?

YES NO

Why do you say this?

Finally, which of these do you think was most successful, and why?

C. MANPOWER PLANNING ROLE

9. Do you feel that the introduction of manpower targets since 1983 has overridden manpower planning, in the sense of formulating staffing requirements and ensuring supply is achieved?

Completely	....
Partly	....
Not at all	....
Not sure	....

Why do you think so, and how has it effected this?

10. Is there a vacancy review procedure operating in the district?

YES NO

If so, what criteria must be satisfied in order to make a case of need, to fill a vacant post?

11. Has the RHA provided you with any advice, guidelines or support in developing the manpower contribution to the current (1984-1994) Strategic Plan?

YES NO

If so, how has it helped you?

12. What role do you personally play in manpower planning?

i Advisory and consultative ....
ii Formulating staffing requirements only ....
iii Formulating staffing requirements and ensuring supply are achieved ....
iv Ensuring supply only is achieved ....

If (i) or (ii), who pursues the issues of ensuring the supply of manpower?

13. Finally, the World Health Organization describes the objective of health manpower planning as being "to specify the number of teams and the composition needed to improve

the level of health up to a proposed level". Does this describe what you currently do?

YES NO

Please can you tell me why you say this?

Thank you for completing this questionnaire.

Please return the completed questionnaire in the pre-addressed envelope.

Annex 2

WORKSHOP ON HFA2000 AND HMD

Held at the
Nuffield Centre
Department of Social Policy and
Health Services Studies
University of Leeds

18-20 February 1985

Objectives

- To identify criteria of health manpower development (HMD) which would be supportive and compatible to the WHO strategy of health for all by the year 2000 (HFA2000);

- To explore current health manpower practices operating in the British NHS against such criteria;

- To examine blocks, difficulties and constraints, and ways to overcome these, in relation to the development of such practices;

- To address such issues in general and to focus in particular on the context of planning services for primary health care as a major thrust of HFA2000.

Working methods

The Workshop was intended to be participative, feeding on the experience and knowledge of participants. Working groups were thus the forum for

debate, with reporting back to the full group. Mr K. Barnard, Senior Lecturer in Health Planning, Nuffield Centre, was the Chairman.

Participants

WHO Regional Office for Europe

Dr J.-P. Menu
WHO Regional Officer for Health Manpower Development (Management)

Dr A. Wojtczak
Director, National Health Policies and Systems

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If health for all is to become a reality,
the present concept of health care should change considerably,
and health care systems should focus on primary health care.
Corresponding changes in the education, training, planning
and management of health manpower should also occur,
so that health personnel work as a team, cooperating with each other
and with the patient and the community to work for health for all.
Can the seeds of such changes be found in current
health manpower practices in the European Region?
What are these practices? What factors influence them?
How do their results differ from or support the strategy of health for all?

Interest in health manpower development has increased
in the cooler economic climate of the 1970s and 1980s.
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has raised further questions about health manpower.
As a first step in answering these questions, the WHO Regional Office
for Europe and the Nuffield Centre, a WHO collaborating centre,
agreed to develop a methodological approach for identifying
national health manpower practices. The Nuffield Centre carried out
a one-year pilot study to examine both health manpower practices
in the United Kingdom and ways to study them.

The study had three objectives: to identify and describe
health manpower practices; to examine their compatibility
with the health for all strategy; and to explore practices
supporting health for all. Its results are informative and interesting.
This report also includes three different success stories,
united in their view of primary health care as a way to promote,
as well as preserve, health. More such studies are needed
to explore the field of manpower practice and planning.